

Kappa Kidney Camp 2011



MEDICAL INFORMATION To be completed by Physician

NAME: _____

Check One: Male Female DOB: _____ Age: _____

Medical Information:

HD CAPD CCPD

Start date of modality: _____

Underlying renal disease:

Transplant Date: _____

Rejection Episode: NO YES

Current Problems: NO YES

If YES, describe: _____

Transplant lab work to be drawn at camp?: NO YES, describe

Other active medical problems: seizures, diabetes, hypertension: NO Yes, describe: _____

Drug Allergies: NO YES, describe _____

Food Allergies: NO YES, describe _____

Routine vital signs during camp: Wt, BP, Temp & how often: NO YES, describe: _____

Special medical needs: ostomy care, dietary or fluid restrictions, NG/NT feeds, incontinence, symptomatic hyper/hypo tension: NO YES, describe: _____

_____ self: NO Yes

intermittent catheterization: NO Yes, frequency: _____

Restricted activities: swimming, boating, wall climbing, sun exposure: NO YES, describe _____

Any behavior problems/ family problems: No Yes, describe: _____

Recent labs (please date):

H/H	K	PO4	CA	BUN/Creat
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All the above information is correct:

MD Signature: _____ Print Full

Name: _____

Facility: _____

Phone: _____ FAX: _____

Primary

Nurse: _____ Phone: _____

Social Worker: _____

Phone: _____